

Vesta Road Surgery New Patient Questionnaire

[www.vestaroadsurgery.co.uk](http://www.vestaroadsurgery.co.uk)

Date	
First Name	
Surname	
Date of Birth	
Address	
Telephone Number	
Mobile Number	
Email Address	
Occupation	

Do you have any special needs?	Yes/No If Yes, Please state:
Are you registered disabled?	Yes/No

**Height =**

**Weight =**

**Ethnicity**

Please tell us your ethnic group. Please choose ONE section only from the list below. Please tick the most relevant  box. If you tick a  box marked OTHER, please write your ethnic group in the space given

<p style="text-align: center;"><b><u>Asian or Asian British</u></b></p> <p><input type="checkbox"/> Bangladeshi</p> <p><input type="checkbox"/> Indian</p> <p><input type="checkbox"/> Pakistani</p> <p><input type="checkbox"/> Other Asian background please write in -----</p> <p style="text-align: center;"><b><u>Black or Black British</u></b></p> <p><input type="checkbox"/> African</p> <p><input type="checkbox"/> Caribbean</p> <p><input type="checkbox"/> Any other Black background please write in -----</p> <p style="text-align: center;"><b><u>Chinese or Other Ethnic Groups</u></b></p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Any other ethnic group please write in -----</p>	<p style="text-align: center;"><b><u>Mixed Background</u></b></p> <p><input type="checkbox"/> White &amp; Asian</p> <p><input type="checkbox"/> White &amp; Black African</p> <p><input type="checkbox"/> White &amp; Black Caribbean</p> <p><input type="checkbox"/> Any other mixed background please write in -----</p> <p style="text-align: center;"><b><u>White</u></b></p> <p><input type="checkbox"/> British</p> <p><input type="checkbox"/> Irish</p> <p><input type="checkbox"/> Any other White background please write in -----</p>
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Main Spoken Language	
Need Interpreter? What Language?	

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**Medical History**

- Do you suffer from any chronic conditions? EG: Asthma, Epilepsy, or high blood pressure?
- Have you had any serious illnesses that were treated in hospital? Please give details including dates when possible. For example: Heart attack, Stroke, Cancer.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thalassaemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart Attack	Other? Please state
<input type="checkbox"/> Stroke	<input type="checkbox"/> High BP	<input type="checkbox"/> Sickle Cell	

**Family Medical History** – Has any family member/s suffered from the following?

Condition	Family Member: e,g Brother, Grandmother.
Heart Disease (Age of onset)	
Asthma	
Stroke	
High Blood Pressure	
Cancer (what type, what of)	
Diabetes	
Other (what?)	

**Are you a carer?**

Do you look after someone who is ill, frail or disabled Yes/No

**Do you have a carer?** (Does someone look after you?) Yes/No

If yes, please tell us their name and telephone number

What is their relationship to you?

**Children’s Immunisations**

Please bring in your child/children’s **Red Book/s** the practice nurse will update their Immunisations record.

**Adult Immunisations** – Please give date of last vaccination for:

Tetanus	Yes/No	Date:
Rubella / German Measles (Women only)	Yes/No	Date:
Other		

**Medications** – Are you taking any drugs or medicines? Yes/No

NB. You must see the Doctor before we issue you with a repeat prescription.

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**Allergies** – are you allergic to any medicines Yes/No  
 If yes, which ones? And what happens if you take them?

**Have you been in Hospital with a serious illness/operation?**

**Tobacco**

Do you smoke?  No  Yes How many a day?  
 Are you an ex-smoker  No  Yes When did you give up  
 Never Smoked

**Alcohol** (1unit = glass of wine, ½ pint of beer or lager, a measure of spirit)

**Fast Screening Tool**

**Pint of Regular Beer/Lager/Cider. Alco-pop or Can of Lager, Glass of Wine (175ml),  
 Single measure of Spirits**

Question	Score 0	Score 1	Score 2	Score 3	Score 4	Total score
How often do you have a drink that contains alcohol?	Never	Monthly or less often	2-4 times per month	2-3 times per week	4 + times per week	
How many standard alcoholic drinks do you have on a typical day when drinking?	1- 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

**Exercise** – Do you take exercise? If so, what? And how often?

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**Contraception**

Do you use any method of family planning/contraception? (Females only)

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**Cervical Smear Data – Females only**

Have you had a smear test?	Yes/No
Date of last smear?	
Clinic/Surgery where smear taken?	
Result of smear?	Normal/Abnormal/Inadequate
Any history of abnormal smear?	
Next smear due?	

**Next of Kin?**

Name:	Contact Number:
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We would only contact your next of kin in an emergency. We do not divulge confidential information to anyone without your permission

**I give consent for the practice to access my medical information from hospitals and previous doctors if necessary for my medical care.**

<b>Signature</b>	<b>Date</b>